Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351258564M
Compliance #: HL351255916C

Date Concluded: December 22,2023

Name, Address, and County of Licensee Investigated:
Beehive Homes of Maple Grove
14901 Weaver Lake Rd
Maple Grove MN
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Maggie Regnier, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) abused a resident when she slapped the resident while providing care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. While in the resident's room and providing cares for the resident, the AP treated the resident in a humiliating and disparaging manner including how she touched and communicated with the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of facility records, resident records, staff records and audio and video tapes. Also, the investigator observed staff to staff interactions, staff and leadership interactions and staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses include Alzheimer's, dementia and insomnia. The resident's service plan included assistance with assistance with medications, bathing, dressing and incontinence care. The resident's assessment indicated the need for cueing for most activities including eating and rest but was able to ambulate without assistance.

A video and audio recording device placed in the room by the resident's family captured interactions between the AP and the resident. The video recordings included two separate occasions when the AP was in the room with the resident to provide cares during the course of one shift.

The first recording showed the AP enter the resident's room and, while straightening the bed covers, the resident walked into view room towards the couch. The audio recorded the AP yell at the resident to wait. The resident replied she was going to sit down the AP yelled again "you wait!"

The same recording showed the AP walk over to the resident, grasp the resident's hand, quickly pull her to the side of the bed, and then forcefully push the resident onto the bed without asking the resident to lay down or explaining what she was doing. The AP then took the resident's legs, lifted them up quickly, and dropped the resident's legs onto the bed.

As the AP finished the cares and prepared to leave the room, she placed the bed sheet and blanket up over the resident's face and walked out of the room. The AP did not ask the resident if she wanted her face covered in this manner.

Later the same shift, a second video and audio recording showed the AP enter the resident room while the resident lay in bed sleeping. As the AP approached the bed, she slapped the resident's foot and then the resident's leg, which caused the resident to flinch both times. The resident sat up partway in bed and said "you [the AP] cannot do this" and reached out her hand. The AP pushed the resident's hand away and said, "You just make more work for people" and "you peed all over."

Next the same recording showed the AP initiate cares by abruptly pulling the resident's pants and briefs down to just above her knees without explaining what she was doing. The AP tapped the resident's arms, then her chest, and said "come on" while making an up motion with her arms. The AP inserted her thumbs into the resident's hands and attempted to pull the resident up out of bed. The AP stopped midway through the transfer stating her thumbs hurt and pulled her hands away from the resident.

At this point, the resident remained on the bed and the AP pulled the sides of the brief apart and put the brief on the floor. Then the AP offered her hands to the resident to help her get up. The AP pulled hard on the resident to get her off the bed and the resident said, "I can't." The

AP put her arm under the resident's arm to stand her up and then walked the resident over to the couch naked from the waist down. The AP placed the resident on the couch, still naked from the waist down, without offering anything to cover her up.

During an interview, a member of the management team stated the facility reviewed the recording. The facility discontinued the AP's employment as the recording showed the AP treated the resident in an unacceptable way while providing cares.

During an interview with the AP, she stated that her care was very compassionate and did not feel she did anything wrong. The AP also stated she was very sorry if she had done anything wrong. The AP also stated she cared for the resident like she cared for her own grandmother.

During an interview, the resident's family member stated he/she reviewed the recording and found it very upsetting to see the resident treated in this manner.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, due to advanced dementia
Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility terminated the AP's employment and provided education to other caregivers on how to treat residents.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Maple Grove City Attorney
Maple Grove Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35125	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MAPLE GROVE	14901 WEAVER LAKE ROAD MAPLE GROVE, MN 55311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On October 31st, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL351255916C/#HL351258564M. For HL351255916C/#HL351258564M. the following correction order is issued: 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	